Unlearning Weight Stigma

The Latest Science on Trauma and Weight

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January/February 2022 (/magazine/toc/197/family-rifts)

A few years back, when professional meetings were all still happening in person, I found myself amidst fellow therapists, grabbing the last seat in a packed conference ballroom. We waited expectantly for the presenter, popular trauma expert Gabor Maté.

After a keynote speech earlier in the day—in which he'd argued that much of our suffering isn't a biological or individual failure, but one stemming from the traumatizing nature of the culture we live in—I realized that Maté's viewpoint aligned with how I see diet culture and the impact of weight stigma.

As a medical doctor offering compassionate addiction treatment in Vancouver, Maté's willingness to see beyond the addiction to the traumatized person it consumes has made him a sought-after teacher in the larger world of trauma treatment. As someone who specializes in binge eating, body image, and weight stigma, I resonated with his capacity to see the entirety of a person in the context of their environment.

So when a workshop participant a few rows behind me stood up to ask him about the connection between "obesity" and trauma, I listened with interest. He correctly pointed out that fat-shaming is a problem, but then went on to say that the reason "obese" people don't lose weight is that they need to keep eating to soothe pain. Almost reflexively, my arm shot up, and before I knew it, a microphone was shoved into my hand.

I leaned into the mic, my heart pounding, and said, “Some people may binge eat to soothe pain, but the assumption that everyone will lose weight if they stop bingeing, or that all higher-weight people binge, is wrong.”

Maté paused, then asked me, “Are you familiar with the work of Vincent Felitti?”

I immediately knew where he was going with this question. Felitti was behind a study that in part suggests that sexually abused women seek to protect themselves from further abuse by gaining weight and keeping it on.

In *The Body Keeps the Score,* trauma specialist Bessel van der Kolk describes how the observations of Felitti, an internist and chief of preventive medicine at Kaiser Permanente, led to the Adverse Childhood Experiences (ACEs) scale. Felitti’s work identified not only the extent to which the general population experiences trauma during their youth, but also gave practitioners a simple ranking scale of traumatic experiences that could help identify who’s more apt to engage in high-risk behaviors—the outcomes of which include addiction, unintended pregnancies, sexually transmitted diseases, and “obesity.”

Felitti’s ideas about the whys of higher weight are now widely accepted, especially the idea that someone of higher weight maintains that weight because of trauma. In fact, more often than not, this is offered up less as a possibility and more as a full-blown assumption on the part of too many professionals. You see evidence of it everywhere, particularity given the popularity of ACEs in the therapy and healthcare worlds. In her book, The Deepest Well, California’s Surgeon General Nadine Burke Harris repeats the story of Felliti’s discovery, saying that it goes, “a long way toward explaining why his most successful patients, the ones who had peeled off that protective layer, were so desperate to put it back on.”

Felitti headed up his “obesity” clinic from the mid ’80s to the late ’90s using what he called supplemented, absolute fasting to bring about dramatic weight loss. Patients ate no solid food, only liquids supplemented by essential vitamins, amino acids, and electrolytes. One of his female patients lost 276 pounds over the course of a year, and when she regained weight, Felitti attributed her rapid weight gain solely to the distress caused by a male coworker beginning to express sexual interest in her.

Ten days after learning of this particular patient's history of sexual abuse, Felitti came across another patient with a history of sexual trauma and rapid weight gain. According to van der Kolk, this was "only the second case of incest Felitti had seen in his 23-year medical practice." But when half of the "obese" clients in the initial study later revealed they'd also been sexually abused, he settled on the idea that there must be a link between higher weight and abuse and a correlation between weight gain and protection against further sexual trauma. He did this without researching rates of sexual abuse among thinner people.

> *"Attributing weight regain to trauma and fear of sexual attention is an outright denial of the science."*

Felitti only having heard about two cases of incest in his career says more about his not knowing to ask his subjects about sexual trauma than it does the frequency of abuse. As we now know, people of all sizes are survivors of incest and sexual assault, and only recently, in the era of #MeToo, have many felt emboldened to share their experience.

From a statistical standpoint, there's nothing surprising about Felitti's finding. Given that two-thirds of Americans fall into a higher-weight category, it's to be expected that the majority of people who've experienced sexual abuse are higher weight. Yet many practitioners today have come to interpret Felitti's work as proof positive that sexual or other trauma underlies most cases of "obesity" and the inability to permanently lose weight.

Psychologist Deb Burgard, a leader in the Health At Every Size movement, puts it this way: "The majority of people who *blink* are higher weight. If sexual abuse and body size are totally unrelated, we'd still see the majority of people who have experienced sexual abuse being higher weight. Someone arguing that fat people are less likely to have experienced sexual abuse could just as truthfully say that the majority of people who have *not* experienced sexual abuse are higher weight."

Even more important than statistics is biology. To those of us who work in this area, it's clear that consistently attributing weight regain to trauma and fear of sexual attention is an outright denial of the science. It's no surprise that Felitti's patients rapidly gained back the weight following extreme fasts. Research on this behavior dates to World War II, when conscientious objectors who agreed to take part in a study on starvation lost a quarter of their body weight and became irritable, depressed, lethargic, and obsessed with food. Once freed to eat what they wanted again, the men binged for weeks but stayed ravenous as their bodies sought to become renourished.

More recently, a study of former participants in *The Biggest Loser* television show demonstrated the physiological consequences of intentional weight loss. When the show began, their metabolisms burned the typical number of calories for their body size; they had slower metabolisms at the end of the show, as would be true for just about anyone who suppresses their weight through intentional weight loss. The big surprise was that their resting metabolisms remained permanently *lowered*, demonstrating that weight regulation is more than a matter of "calories in and calories out."

Bingeing after a diet is every body's natural way of trying to protect itself from perceived famine. A recent weight loss study of nearly 300,000 people found that within five years, between 95 and 98 percent of people had gained back all of their lost weight or more. Felitti was reportedly looking for a trigger event to explain weight regain: it never occurred to him that the physiological response to dieting for weight loss might be it.

Don't Assume You Know Your Client's History

There's no doubt that bingeing is a survival strategy for many trauma survivors, including sexual assault survivors, and that it can lead to weight gain, especially if they try to change their weight through dieting. But I reject the implication that all higher-weight people who try to lose weight and then gain it back should be assumed to do so to protect themselves from sexual attraction or trauma-based shame.

Why does this distinction matter so much?

When those of us in the therapy world assume that higher-weight individuals have a sexually or otherwise traumatic past, it adds another layer to the fat-shaming and weight stigma they're already likely enduring. And as Gabor Maté emphasized in his presentations, exposure to stigma worsens physical health.

In the book *Anti-Diet*, intuitive eating dietician Christy Harrison explains the impact of weight stigma on "allostatic load," or the cumulative effect of chronic stressors on multiple systems in the body, which can worsen conditions like diabetes and heart disease. A large, 10-year study found those impacted by weight stigma were twice as likely to have a high allostatic load, making it "an *independent* risk factor for physiological stress."

Along these lines, therapists should be aware that within size-acceptance communities, the word *fat* has been reclaimed as a neutral adjective or positive identity, and that, as I expressed to Maté, the term obesity is in itself a fat-shaming word. In 2013 the American Medical Association declared, against the recommendations of its own scientific advisory board, "obesity" to be a disease. Higher-weight people with health markers that fall in a normal range are now considered diseased within the medical field, including, according to one study, 54 million people incorrectly labeled as unhealthy when relying on the BMI.

If you check in with your higher-weight clients, you'll find the probability that they *haven't* been fat-shamed by the medical community to be extremely low. What's more likely is that they've been given harmful medical interventions in the name of weight loss, while not receiving adequate medical care for actual health conditions. They certainly don't also need their therapists to be offering interventions based on stigma and stereotypes.

Take my recent conversation with Grammy-nominated singer Mary Lambert, a fat, queer woman best known for her collaboration with Macklemore on the song *Same Love*. "Over the course of my life, I've had several therapists tell me that I was fat because I subconsciously wanted to be undesirable and desexualized after sexual trauma," she said. "I didn't see it as a harmful thing at the time, but in retrospect, the fact that some therapists perpetuate the concept of pathologizing fatness is incredibly awful and damaging. Women who've been sexually assaulted or experienced trauma deserve coping mechanisms that aren't harmful—what a blessing, then, is food! Not a drug or an addictive substance, just the comfort of fullness. I'm so thankful for those behaviors that soothed me at a painful time. But we also have to

stop attributing the behaviors of 'emotional eating' to every fat person, and interrupt the belief that thin people don't 'emotionally eat.' Separate the behavior from the characteristic of being fat. They are two different things, and you have no idea what someone's habits are."

Lambert's healed many of the wounds of her trauma, made peace with food, and found a loving relationship—and she remains at a higher weight. If our anti-fat bias leads us to conclude she must still be protecting herself from unwanted sexual attention, must have a food problem, is physically unhealthy, or even that higher-weight people can't be sexually desirable, then we're complicit in upholding weight stigma and promoting the interventions for weight loss that are so damaging.

Fat-Shaming with a Clinical Brush

I hear this dread of fat assumptions, fat-shaming, and diet prescriptions by professionals from many of my clients. You very likely have clients who also feel this dread. Perhaps you feel it too.

Higher-weight people often avoid going to doctors or therapists because the stigma they experience is untenable. We know that, for example, fat women have higher rates of cervical cancer because they're likelier than thin women to avoid getting Pap smears due to the weight discrimination and prejudice they experience at the doctor's office.

Fat-shaming and weight discrimination can even prove deadly. Take the case of Ellen Maud Bennett, a higher-weight woman repeatedly told by medical providers that weight loss was the solution to her ailments, when it turned out she actually had cancer. Her obituary reads, "A final message Ellen wanted to share was about the fat-shaming she endured from the medical profession. Over the past few years of feeling unwell, she'd sought out medical intervention, but no one had offered any support or suggestions beyond weight loss. Ellen's dying wish was that women of size make her death matter by advocating strongly for their health and not accepting that fat is the only relevant health issue."

The therapy community has long prided itself on being an alternative to the hurried and often insensitive medical establishment, but it continues to contribute to the problem. If we automatically paint our higher-weight clients with a clinical brush labeled "sexual trauma survivor," we'll only further alienate clients already sensitive to our anti-fat biases,

promote the unnuanced belief that fat is a mental health issue, and expect weight loss to be evidence of healing.

Among the revered work of existential therapist Irvin Yalom is his story "Fat Lady," in which he describes his strong reaction to the fat body of his client Betty. In an afterward written 25 years later that acknowledges the letters he received from higher-weight women about the story's offensiveness, he owns the detrimental impact of his bias and says therapists need to openly explore similar biases in supervision so they're not imposed on the client.

According to The Rudd Center, "Psychologists ascribe more pathology, more negative and severe symptoms and worse prognosis to obese patients compared to thinner patients presenting identical psychological profiles," and a recent review of Harvard's implicit bias studies showed a decrease in all categories *except* weight bias.

Given that we have no evidence-based means of achieving sustainable weight loss for the vast majority of people, we also need to ask ourselves, why do we continue to use weight loss as a measure of psychological healing? Aubrey Gordon, author of *What We Don't Talk About When We Talk About Fat,* writes, "Whatever we want to think about ourselves, we've got to make the shift from thinking of anti-fat bias as something we decide to do out of animus to something that exists within us unless and until we uproot it."

Binge eating is an issue that can benefit from treatment, and it does attach to trauma. But questions about a history of any trauma should be asked of all clients, not just those at higher weights. And when working with clients who want to explore issues related to food and/or body size, it's important to ask the right questions, such as, What can you tell me about your relationship with food? When was the first time someone said your body was a problem? What do you think would be different in your life if you lost weight? How have you been impacted by weight stigma and bias?

It's important to remember that your higher-weight clients often experienced weight-related bullying and shaming in childhood by peers, family, and health professionals. These messages become engrained in the psyche, referred to as internalized weight stigma. According to Amy Pershing, coauthor of *Binge Eating Disorder: The Journey to Recovery and Beyond*, the pathologizing of body size and prescriptions to restrict food intake limit their opportunity to identify and honor physical cues for hunger and fullness, and many have significant diet and weight-cycling histories as a result.

When There is Trauma and Binge Eating

When binge eating is revealed to be a strategy for coping with emotional distress, therapists should be aware that developing body awareness and trust plays a critical role in lessening the impact of traumatic activation. But this is difficult when survivors of physical and sexual trauma experience connection with their bodies as a trigger for shame.

Now in his late 30's, my client Tyler grew up in a physically abusive home with an alcoholic father. Once, when he was in middle school and engrossed in a book, his dad called for him downstairs. When Tyler didn't respond immediately, his father stormed up the stairs and broke down his door, yelling, "You lazy, fat slob!" For the rest of his childhood, Tyler had no bedroom door, thus no privacy amid the chaos in his home. Food became his go-to for soothing or numbing, and bingeing followed him through his college years and beyond, eventually becoming woven into his psyche as a way to care for himself.

Now a manager at a large corporation, Tyler's embarrassed by his binge eating and higher-weight body. This came to a head when his company offered employees a reduction in insurance rates determined by their weight. When Tyler first contacted me, he desperately wanted to lose weight so he could save money and "fit in better" with coworkers. But no matter how many weight-loss strategies he had tried, he couldn't get his weight "under control."

We worked with the concept of attuned eating, also known as intuitive eating, with full recognition that working his way out of a diet mindset would take time. He managed to decrease the frequency of bingeing, but the pace of progress frustrated him, and he wanted to know when he would be "cured." Though I couldn't tell him how long it would take to heal his relationship with food, I wanted him to develop compassion for his need to turn to it during times of distress.

Over time, Tyler came to appreciate how bingeing as a child helped him survive a chaotic, unpredictable, and sometimes dangerous household. He began to understand that when his past trauma became activated, food was still his best option at times for calming his nervous system. He felt both angry and helpless that his workplace was essentially punishing him for his weight, especially now that he understood how dieting for weight loss actually exacerbated his binge eating.

As we focused on building new skills to meet his needs in addition to turning to food, he began to notice that more time lapsed between binges, and that when a binge did occur, he could end it sooner than in the past. He also focused on ways to care for his body that did not require the pursuit of weight loss, including seeking medical care for his health conditions from a weight-neutral doctor.

Anti-fat bias inherently assumes a thin body to be healthier, more desirable, and even virtuous. There is a “goodness” about being thin. This moralization of size further reinforces the body-shame narratives clinicians are trying to treat, so it’s imperative that we recognize we’re at cross purposes if we’re trying to help clients heal from body shame by focusing on changing their bodies. Even if weight gain is the result of a trauma-driven eating disorder, the reality is that a client may or may not lose weight in the course of recovery, and that’s what it means to be “weight neutral.”

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Ultimately, Gabor Maté responded to my comments with openness and curiosity when I made my point at his workshop, and we continued our conversations throughout the conference. I’ve heard from many clients and colleagues that they find resources such as The Body Keeps the Score and The Deepest Well extremely helpful in their understanding of their own and their clients’ trauma, but they’re triggered by the Felitti material that blames body size on trauma, promotes weight loss, and ignores the lived experience of higher-weight people.

As mental health clinicians, we can do a better job of not contributing to this triggering. We can use language that describes the actual behavior—which is bingeing—and stop conflating “obesity” with trauma. We can understand the science of weight regulation and stop viewing higher-weight bodies as pathological. I also urge those who treat trauma—and especially those who are leaders in the field—to familiarize themselves with the true nature of weight-based trauma so as not to further traumatize, albeit unintentionally, people who already experience weight stigma.

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